State: Florida

Demonstration Name: Florida Medicaid Reform

Description & Status:

According to information provided by the State, under the demonstration, most Medicaid beneficiaries in five counties are required to enroll in a managed care plan (either a capitated health plan or a fee-for-service Provider Service Network plan) as a condition of eligibility for Medicaid. Participation is mandatory for TANF-related populations and the aged and disabled with some exceptions. The demonstration allows plans to offer customized benefit packages and reduced cost sharing, although each plan must cover all mandatory services, and all State plan services for children and pregnant women (including EPSDT). The demonstration offers Enhanced Benefits Accounts and established a Low Income Pool (LIP) to ensure continued support for the provision of health care services to Medicaid, underinsured and uninsured populations.

Populations:

The Demonstration serves the following populations:

- Families whose income is below the TANF limit with assets less than $2,000; and
- Poverty-related children whose family income exceeds the TANF limit; up to age one, family income up to 185 percent of the Federal poverty level (FPL); up to age 6, family income up to 133 percent of the FPL; and up to age 21, family income up to 100 percent of the FPL.
- The aged and disabled, comprising persons receiving Supplemental Security Income (SSI) cash assistance whose eligibility is determined by the Social Security Administration (income limit approximately 75 percent of the FPL; asset limit for an individual is $2,000); and
- Children eligible under SSI.

Approval Date: October 19, 2005

Effective Date: July 1, 2006

Renewal Date: December 15, 2011

Expiration Date: June 30, 2014

Pending Actions:

On August 1, 2011, the State submitted amendments to the demonstration to expand managed care State wide and make changes to benefits and cost-sharing.

FLORIDA MEDICAID REFORM
SECTION 1115 DEMONSTRATION
FACT SHEET

Name of Section 1115 Demonstration:	Florida Medicaid Reform
Waiver Number:	11-W-00206/4
Date Proposal Submitted:	October 3, 2005
Date Proposal Approved:	October 19, 2005
Date of Implementation:	July 1, 2006
Date Expires:	June 30, 2011
Date Extension Proposal Submitted:	June 30, 2010
Date Extension Proposal Approved:	December 15, 2011
Date Expires:	June 30, 2014

Summary

The Florida Medicaid Reform Demonstration was initially implemented in Broward and Duval Counties July 1, 2006, then expanded to Baker, Clay, and Nassau Counties July 1, 2007. The extension of the Demonstration that was effective December 16, 2011, allows the Demonstration to continue to operate in the five counties where it has been implemented.

According to information provided by the State, under the demonstration, most Medicaid eligibles in five counties are required to enroll in a managed care plan (either a capitated health plan or a fee-for-service Provider Service Network plan) as a condition of eligibility for Medicaid. Participation is mandatory for TANF-related populations and the aged and disabled with some exceptions. The demonstration allows plans to offer different benefit packages and reduced cost sharing, although each plan must cover all mandatory services, and all State plan services for children and pregnant women (including EPSDT). The demonstration offers Enhanced Benefits Accounts and established a Low Income Pool (LIP) to ensure continued support for the provision of health care services to Medicaid, underinsured and uninsured populations.

The extension of the Demonstration that was effective December 16, 2011, incorporated modifications and protections to ensure access to and quality of care, and that improve transparency, accountability, and stability in the Demonstration.

- Provided increased protections for beneficiaries through network adequacy and access requirements;
- Ensured increased stability among managed care organizations and provider service networks to minimize plan turnover;
- Required the State to implement a Medical Loss Ratio (MLR) of 85 percent for pre-paid plans operating under the Demonstration;
- Provided for an improved transition and continuity of care when beneficiaries are required to change plans;

- Discontinued the option for beneficiaries to Opt Out of Medicaid and receive premium assistance to access employer sponsored insurance. (Beneficiaries participating in the old Opt Out program will have the option to continue to access employer sponsored insurance under the State plan premium assistance program, or return to Medicaid managed care under the Demonstration.)
- Eliminated the State's ability to impose a maximum annual benefits level for Medicaid beneficiaries; and,
- Established evaluation mechanisms such as encounter data requirements to ensure that each plan's encounter data are submitted in a timely manner, and are complete and accurate.

Amendments

On November 25, 2009, the State requested to uncouple the statewide expansion requirement from access to the LIP funding in Demonstration year five (7/1/2010 – 6/30/2011). This amendment was approved on January 29, 2010.

Eligibility

Mandatory Populations - Participation in Medicaid Reform is mandatory for the 1931 eligibles and related group referred to as the Temporary Assistance for Needy Families (TANF) and the TANF-related eligibility group, and the Aged and Disabled group. These populations are described as follows:

- Families whose income is below the TANF limit (23 percent of the FPL or $303 per month for a family of 3) with assets less than $2,000; and
- Children whose family income exceeds the TANF limit; up to age one, family income up to 185 percent of the FPL; up to age 6, family income up to 133 percent of the FPL; and up to age 21, family income up to 100 percent of the FPL.
- The aged and disabled, comprising persons receiving Supplemental Security Income (SSI) cash assistance whose eligibility is determined by the Social Security Administration (income limit approximately 75 percent of the FPL; asset limit for an individual is $2,000); and
- Children eligible under SSI.

Voluntary Participants – The following individuals are excluded from mandatory participation but may choose to be voluntary participants in the Demonstration.

- Foster care children;
- Individuals with developmental disabilities;
- Individuals residing in an institution such as a nursing home, sub-acute inpatient psychiatric facility for individuals under the age of 21, or an ICF-DD;
- Individuals receiving hospice services;
- Pregnant women with incomes above the 1931 poverty level;
- Dual eligible individuals;
- Medikids under title XXI; and
- Children under age 1 with family income 186 percent – 200 percent of the FPL under title XXI.

Excluded from Reform Participation – The following groups of Medicaid eligibles are excluded from participation in the Demonstration.

- Individuals whose immigration status is as a refugee eligible;
- Individuals eligible as medically needy;
- Individuals residing in State mental facilities (over age 65);
- Family planning waiver eligibles; and,
- Individuals eligible as women with breast or cervical cancer.

Delivery System

The State contracts with multiple managed care plans to provide services. Managed care plans include Health Maintenance Organizations (HMOs) and Provider Service Networks (PSNs). The MCOs and PSNs must be authorized by State Statute and must adhere to 42 CFR 438. The State reimburses HMOs on a capitated basis and PSNs on a fee-for-service basis.

Benefits

Benefit Packages for Medicaid Reform **–** Capitated plans have the flexibility to provide customized benefit packages for Demonstration enrollees. The customized benefit packages must include all State Plan services otherwise available under the State plan for pregnant women and children including all EPSDT services for children under age 21. The customized benefit packages must include all mandatory services specified in the State plan for all populations. The amount, duration, and scope of optional services, may vary to reflect the needs of the plan's target population and plans can offer additional services and benefits not available under the State plan. The plans authorized by the State shall not have service limits more restrictive than authorized in the State plan for children under the age of 21 and pregnant women.

Enhanced Benefits Account Program (EBAP) - This program provides direct incentives to Demonstration enrollees who participate in State defined activities. Individuals who participate earn credits which may be used for health care expenditures as approved under the program.

Low Income Pool (LIP) - The LIP provides direct payment and distributions to safety net providers in the State for the purpose of providing coverage to Medicaid, uninsured, and underinsured populations. The LIP consists of a capped annual allotment of $1 billion, total computable, during each year of the Demonstration.

Quality and Evaluation Plan

The State of Florida must conduct an evaluation of the Demonstration. The evaluation design must include a discussion of the goals, objectives and specific hypotheses that are being tested through organizational analyses, utilization and payment analyses, and quality of care analyses. The domains of focus for the evaluation are as follows:

- The effect of managed care on access to care, quality and efficiency of care, and the cost of care;
- The effect of customized benefit plans on beneficiaries' choice of plans, access to care, or quality of care;
- Participation in the Enhanced Benefits Account Program and its effect on participant behavior or health status;
- The impact of the Demonstration as a deterrent against Medicaid fraud and abuse;
- The effect of LIP funding on the number of uninsured and underinsured, and rate of uninsurance;
- The effect of LIP funding on disparities in the provision of healthcare services, both geographically and by population groups;
- The impact of Tier-One and Tier-Two milestone initiatives on access to care and quality of care (including safety, effectiveness, patient centeredness, timeliness, efficiency, and equity);
- The impact of Tier-One and Tier-Two milestone initiatives on population health; and,
- The impact of Tier-One and Tier-Two milestone initiatives on per-capita costs (including Medicaid, uninsured, and underinsured populations) and the cost-effectiveness of care.

As required under applicable Federal laws and regulations, quality of care furnished under the Demonstration is subject to internal and external review. The State also ensures the effectiveness and quality of care by monitoring access, utilization practices, and beneficiary information as well as through established service standards in contracts with MCOs.

Cost Sharing

The State must pre-approve all cost sharing assessed by managed care plans. Cost sharing must be consistent with the State plan except that Reform plans may elect to assess cost sharing that is less than what is allowed under the State plan.

State Funding Source

The State of Florida certifies that State/local monies are used as matching funds for the Demonstration and that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law.

Updated 12/2011